STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
OFFICE OF CONSUMER AFFAIRS
CORDELL HULL BUILDING, THIRD FLOOR
425 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37243

Certified Peer Support Specialist Certification Renewal Application

Please Print

PART I – Applicant Contact Information and Verification of Status

Full Name: _____

Certification Number: _____ Certification Date: _____

Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: (_____) _____ - _____

Email: _____

	Circle:
• I am currently employed by an agency licensed by the TDMHDD.	Yes ☐ No ☐
• I am under the general supervision of a mental health professional.	Yes ☐ No ☐
• I perform duties specified in the CPSS Scope of Activities.	Yes ☐ No ☐
• I have successfully completed twenty (20) hours of recognized on-going education.	Yes ☐ No ☐
• I have had no reports of violation of the CPSS Code of Ethics.	Yes ☐ No ☐

If you circled "No" on any of the statements above, please explain: _____

_____

_____

_____

_____

Please Print

PART II – Verification of On-going Education

Twenty (20) hours of on-going education are required annually to maintain active certification and must be earned within the annual certification period. Please refer to Section VI of the CPSS Handbook for On-going Education requirements.

List the title and date of the training, the sponsoring organization, and the number of hours for each training attended. Submit this application with a copy of the Certificate of Attendance or Completion for each training listed.

1) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

2) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

3) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

4) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

My signature below affirms that all of the information attached to and contained in this certification renewal application is true and correct to the best of my knowledge. I understand that knowingly providing false information shall be grounds for termination of certification.

_____ _____
Signature of Applicant Date

Note: The Certification Renewal Application and all required documentation must be submitted at least forty-five (45) calendar days prior to the end of the current certification period.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
OFFICE OF CONSUMER AFFAIRS
CORDELL HULL BUILDING, THIRD FLOOR
425 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37243

Certified Peer Support Specialist Certification Renewal Application

Please Print

PART III – Employment Summary – Completed by the supervising mental health professional and faxed to the Office of Consumer Affairs at 1.615.253.3920.

A Certified Peer Support Specialist must be under the general supervision of a mental health professional licensed by the State. The licensed mental health professional must work for an agency that is licensed by TDMHDD and authorized to participate in the Medicaid program. Provide the following information regarding the agency staff that provides direct supervision:

Supervisors' Name: _____

Credentials: _____ Position: _____

Agency: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ - _____ ext. _____

Email: _____

Applicant's Name: _____

Applicant's job title within the agency: _____

Full-time / part-time (circle one) Number of hours worked per week: _____

Certification number: _____ Certification Date: _____

Circle:

- The applicant is employed by an agency licensed by TDMHDD. Yes ☐ No ☐
- The applicant is under my general supervision. Yes ☐ No ☐
- The applicant performs duties specified in the CPSS Scope of Activities. Yes ☐ No ☐
- The applicant has successfully completed twenty (20) hours of recognized on-going education. Yes ☐ No ☐
- The applicant has had no reports of violation of the CPSS Code of Ethics. Yes ☐ No ☐

Please Print

If you circled "No" on any of the statements above, please explain: _____

_____

I verify that all of the information contained in this document is true and correct to the best of my knowledge, and that the above named applicant is employed by an agency that is licensed by TDMHDD and authorized to participate in the Medicaid program.

Signature of Supervising Mental Health Professional Date

Do Not Write Below This Line

Internal TDMHDD – OCA Use Only

Date received: _____

Date reviewed: _____ Approved _____ Not-approved _____

Date letter of findings mailed to applicant: _____

Date information recorded in data-base: _____

Notes: _____

Processed by: _____